IMPORTANT...

Admission & Application Information:

Contact Information:

(Application Info./Admissions):
Debbie Slemp
Director of Social Services
Admissions Coordinator
Phone:(859) 858-2814
Fax #: (859) 858-4039

(Financial Questions):
Ruth Lynch
Financial Officer
Phone: (859) 858-2814
Fax #: (859) 858-4039

*If you have any questions about your application, or the admission process, please contact Debbie Slemp.

*If you have financial questions, call Ruth Lynch.

*We are in the office Monday thru Friday, but our actual working hours may vary from day to day. Please call ahead and make an appointment before coming to the facility. We do not want you to make a long drive only to find out we are not in and/or do not have an appointment time open. Otherwise, leave us a voice mail and we will get back with you as soon as possible. Please remember to speak slowly, clearly, and to spell anything we may have trouble understanding on the answering machine.

Thank you.

Kentucky Department of Veterans Affairs
Office of Kentucky Veterans Centers
1111 B Louisville Road
Frankfort, Kentucky 40601
Phone: (502) 564-9281 FAX: (502) 564-4036

Dear Potential Resident/Family Member:

Thank you for your interest in the Kentucky Veterans Centers. We realize that the decision to place a loved one into a long-term care facility is not an easy one, and our goal is to make the transition as effortless and pleasant as possible.

At the top of the enclosed application you will find the names of the three state veteran's nursing homes we operate. Please check the box beside the home or homes in which you are interested in applying for admission.

There are admission coordinators at each home who are trained to assist, guide, and direct you through the application process. The address and telephone numbers of the admission coordinators are listed below, and we encourage you to contact them for any assistance needed.

In order to expedite the process, we have attached a list of items that are needed to help determine your eligibility, level of care, and financial responsibility. Please forward these items to us along with your completed application. Again, if any assistance is needed, please do not hesitate to contact one of the below facilities.

Thomson-Hood Veterans Center	Eastern Kentucky Veterans Center	Western Kentucky Veterans Center
ATTN: Admissions Coordinator - Debbie Slemp **Financial – Ruth Lynch**	**ATTN: Admissions Coordinator – Steve Noe** **Financial - Marsha Jett**	**ATTN: Admissions Coordinator – Lisa Ware** **Financial – Lisa Foster**
100 Veterans Drive	200 Veterans Drive	926 Veterans Drive
Wilmore, KY 40390	Hazard, KY 41701	Hanson, KY 42413
859-858-2814	606-435-6196	270-322-9087
800-928-4838	877-856-0004	877-662-0008
FAX 859-858-4039	FAX 606-435-6201	FAX 270-322-9497
TTYS 859-858-4226	TTYS 606-435-6203	TTYS 270-322-9752

We appreciate your service to the nation and extend our gratitude for the opportunity to serve you, the veterans of America's Armed Forces!

Sincerely,

Gilda C Hill

Gilda Hill, Acting Executive Director
Office of Kentucky Veterans Centers

☐ Thomson-Hood Veterans Center
100 Veterans Drive
Wilmore, Kentucky 40390

☐ Eastern Kentucky Veterans Center
200 Veterans Drive
Hazard, Kentucky 41701

☐ Western Kentucky Veterans Center
926 Veterans Drive
Hanson, Kentucky 42413

Please place a check in the box next to the home you are interested in.

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the Kentucky Veterans Centers.

INSTRUCTIONS:

1. Applications must be TYPEWRITTEN or PRINTED IN INK.

2. Veterans must have anything other than a dishonorable discharge and meet those criteria required by the United States Department of Veterans Affairs for veteran's status.

3. Applicant must be a resident of Kentucky.

COUNTY OF RESIDENCE: Where is the veteran currently living/receiving care	DATE:

In compliance with the eligibility requirements, I do hereby apply for admission to the Kentucky Veterans long term care facility checked above, and declare the following statements and information to be true:

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET OR RFD)	TELEPHONE NUMBER
CITY, COUNTY, ZIP CODE	

DATE OF BIRTH	SEX	AGE
PLACE OF BIRTH		RELIGION

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED (PLEASE PROVIDE DATES AND COPIES OF EACH)
☐ WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE)
☐ LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)

NAME OF SPOUSE (maiden name)	SPOUSE'S SOCIAL SECURITY NUMBER
SPOUSE'S ADDRESS	SPOUSE'S DATE OF BIRTH

DATE AND PLACE OF MARRIAGE (PLEASE PROVIDE COPY OF MARRIAGE LICENSE)

MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge)

BRANCH AND SERVICE NUMBER	DATE AND PLACE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE

IF YOU HAVE EVER BEEN A RESIDENT OF THE KENTUCKY VETERANS CENTER OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:

DATE OF DISCHARGE	FACILITY	REASON

HAVE YOU BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST SIX MONTHS? ☐ Yes ☐ No
If Yes, please complete the following:

Name of Hospital/Private Physician	Address of Hospital/Physician
Name of Hospital/Private Physician	Address of Hospital/Physician

DO YOU HAVE MEDICARE? ☐ YES ☐ NO PART A_____ PART B_____ EFFECTIVE DATES: _____ MEDICARE NUMBER _____ (Provide copy)	DOES YOUR SPOUSE HAVE MEDICARE? ☐ YES ☐ NO MEDICARE NUMBER_____ (Provide copy)
DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE: ☐ Yes ☐ No COMPANY AND NUMBER_____ (Provide copy & verification of premium due)	DOES YOUR SPOUSE HAVE ANY OTHER HEALTH/MEDICAL INSURANCE ☐ YES ☐ NO COMPANY AND NUMBER_____ (Provide copy & verification of premium due)

INCOME AND ASSETS

YOU HAVE TWO OPTIONS FOR PAYMENT; IF YOU CHOOSE NOT TO DISCLOSE YOUR ASSETS, PLEASE READ THE FOLLOWING STATEMENT AND SIGN:

I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I UNDERSTAND THAT I WILL BE ASSESSED THE MAXIMUM AMOUNT FOR EXTENDED CARE SERVICES AND AGREE TO PAY THE MAXIMUM CHARGE.

SIGNATURE **DATE**

YOUR SECOND OPTION IS TO DISCLOSE YOUR ASSETS AND YOU WILL BE CHARGED BASED ON YOUR ABILITY TO PAY. IF YOU ELECT THIS OPTION, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

LIST ALL REAL ESTATE YOU AND/OR YOUR SPOUSE OWN OR IN WHICH YOU AND/OR YOUR SPOUSE HAVE ANY INTEREST. (Give location, size, description and approximate value. State whether held solely or jointly with husband/wife).

LIST ALL SECURITIES WHICH YOU AND/OR YOUR SPOUSE OWN. (Include cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money or securities. Give amount and where located). (Provide verification of all securities listed).

LIST THE PERSONAL PROPERTY WHICH YOU AND/OR YOUR SPOUSE OWN. (Include auto, truck, livestock, furniture, farm equipment, business inventory, etc. Give approximate value and where located).

LIST ANY INDEBTEDNESS OTHER THAN THAT SECURED BY YOUR PRIMARY RESIDENCE. (Include amounts, payee, due dates and reason for indebtedness).

LIST ANY INSURANCE POLICES WHICH YOU AND/OR YOUR SPOUSE HAVE. (Include burial, life, hospital, health and accident. Give name of company and face and/or current cash value). (Provide copies).

LIST GROSS AMOUNTS OF MONTHLY INCOME:	VETERAN	SPOUSE
Wages	$	$
VA Pension	$	$
Service Connected Disability _____Percentage	$	$
Social Security	$	$
Medicare	$	$
Retirement Income	$	$
Pension Income	$	$
Other Retirement Income	$	$
Interest	$	$
Dividends	$	$
Income from rental properties	$	$
Court Mandated(Alimony, Child Support)	$	$
Other Income	$	$
Other Income	$	$

PERSONS TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached).	
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE

BURIAL ARRANGEMENTS
Name of Undertaker to be called
Address of Undertaker
Desired Location of Burial
Name of person taking care of arrangements, if any

CERTIFICATION

I_____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the facility. I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the Commonwealth of Kentucky and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the staff such transfer is necessary. This application is my free and voluntary act.

I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the Kentucky Veterans Center is subject to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the Kentucky Veterans Center.

I also understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.

I understand that non-medical leaves of absence from the facility in excess of twelve (12) calendar days per year will result in a charge of the regular monthly charge plus the current VA per diem rate in effect at the time of absence. Absences from the facility will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period.

I understand that the resident is allowed ten (10) consecutive days during medical leaves of absence (hospital stays). Medical leaves of absence may occur more than once in a calendar year. A hospital stay will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period. Resident/Responsible Party will be given the opportunity to continue to hold the bed at a charge of the monthly fee plus the VA per diem rate. In order to be eligible for a bed hold, the veteran must have established residency by being in the facility for thirty (30) consecutive days before leave is taken.

I hereby authorize the Kentucky Veterans Center to apply for any financial benefits to which I may be entitled.

I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.

Signature of Applicant (or Legal Representative) Date:

Documentary support which must be provided prior to admission includes but is not limited to the following:

- Medical records from all healthcare providers seen in the six months prior to application and extending to date of admission including recent hospital admissions
- Verification of Kentucky residency, (mail items showing current address, utility bills, driver's license, etc.)
- Copy of power of attorney/guardianship papers
- Copy of living will/advance directives
- Copy of discharge from military service, (DD214), or other military document showing dates of service
- Copy of military ID, if military retiree
- Copy of social security card
- Current history & physical, (within past 30 days)
- Current medication/treatment list, including herbal and over the counter meds
- Current PPD skin test status or proof of negative chest X-ray
- Current height and weight

If the applicant is currently in a nursing facility, please provide the additional information:

- Nursing monthly summaries
- Nursing notes for previous 3 months
- MDS Assessment and Care Plan
- Social Services notes
- Diet information
- Current medication list
- Immunization records
- Skin assessment
- Recent lab reports
- Proof of all income amounts listed herein.

FINANCIAL INFORMATION REQUIRED FOR ADMISSION:

- Verification of ALL GROSS income amounts applicant or spouse receive per month
- Income from previous year (pensions, social security, interest, dividends, retirement)
- Total out of pocket medical expenses for prior year (Medicare premium, health insurance premium, co-pay for office visits, medications, eye glasses, hearing aids)
- Copies of check and check stubs applicant receives for income that is not directly deposited – gross amount before withholding.
- Copy of tax return for the previous year, if applicable
- Copy of monthly premium paid on supplemental health insurance for applicant and spouse
- Copies of last three bank statements for checking and savings accounts
- Documentation of Market value of any property other than applicant's primary residence
- Documentation of Market value of additional vehicles other than applicant's primary vehicle
- Copies of Certificates of Deposit, IRA's, Stocks, Bonds, Money Market Accounts, Life Insurance Policies (cash value) and Burial Funds
- Copies of outstanding debts i.e. medical bills, credit cards
- Copy of current marriage license
- Letter from current nursing or most recent nursing home to verify financial obligation is being met or has been met

WHAT TO BRING???

PERSONAL ARTICLES to bring for ADMISSION

Upon admission residents do not need large amounts of clothing due to our laundry facility laundering their clothing daily. We recommend only the items listed below, in order to keep closets from becoming cluttered and to avoid wrinkling of clothing.

The facility furnishes all blankets, bedspreads, sheets and pillows; you may bring 1 extra blanket if desired.

The facility will label all clothing items for you. We have an iron-on labeling machine that prints iron-on labels for our residents clothing. If you bring in any new/additional clothing items, (ie. birthdays, Christmas, change of season, etc.), please make sure you take them to the nurse manager or social worker to be labeled "before" you put them in their room/closet. If they get taken down to laundry in the dirty clothes and are not labeled, they have no way of knowing who to return them to.

If you bring any "non" clothing items, (such as pictures, radio, clock, etc.), you will need to label these items with a sharpie marker or ink pen prior to bringing them in. We also encourage you not to bring anything of great value. If an item is lost, please notify your nurse manager or social worker as soon as possible. We will make a diligent effort to find the lost item, and return it, but we are not responsible for lost/stolen items.

Check List for Personal Articles

Shirts/blouses	**8-10**
Pants/slacks	**8-10**
Undershirts	**10**
Underwear	**10**
Socks	**10**
Belts/Shoes	**2 ea**
Handkerchiefs	**12**
Housecoat	**1**
Pajamas/gown	**4**
Sweaters/Light	**2 ea**
Winter coat	**1**

FURNITURE and ROOM FURNISHINGS

Televisions: All rooms are equipped with a TV that is on a pivotal arm, (ie. they can move it to watch TV from their bed or their side chair). **NO other TV's may be brought in.**

Furniture: ALL rooms are furnished with a bed, chest of drawers—top drawer has a lock/key, wall shelf, side chair, and a nightstand.

No other furniture items may be brought in without "prior" approval from the administrator. All rooms have a closet space with a large drawer for each resident. We must be careful not to infringe upon other residents space in the room, and therefore can not allow the rooms to be cluttered. Clutter can also cause falls and limit adequate room for staff to provide care.

Closets: We need you to assist us in keeping the residents' closets neat and stocked with appropriate clothing. Please go through their clothing items every few months, to make sure any torn/tattered items are removed, and/or that seasonal items are exchanged out. Closet space is limited and we want our residents to look nice and be comfortable at all times. Please take home any non-seasonal items or items that no longer fit. *Please remember to give any new/additional items you bring in to the nurse manager or social worker so they can be labeled. They will take them down to laundry for labeling and put them away when they are brought back to the unit.

Electrical Devices: ALL rooms are equipped with electrical outlets.

No extension cords or power-strips can be used in resident rooms. You may bring in a clock/radio but they must be in safe operating order, (ie. no frayed wires/cords, broken cases, etc.). Wireless internet is provided for personal laptops, which are the only type of computer allowed in resident rooms due to space limitations. The Library has computers for residents to use.

Food/Snacks: Residents may keep snacks in their room. However, they must be dated, kept in an air-tight container, and limited to small quantities. Close monitoring of all stored food items is important due to infection control.

No food items that require refrigeration may be kept in the room. Items requiring refrigeration need to be checked in with nursing and labeled with the residents name.

All nursing units have a kitchenette with a refrigerator for these items to be stored. We encourage residents/family to inspect their snacks frequently to make sure they do not become outdated or unfit for consumption.

Free snacks are also provided daily on the nursing units.

MEDICATIONS:

NO Outside Medications

NO outside medications may be brought in for residents.

Only medications administered by THVC are permitted. It is very dangerous for residents to consume or use outside medications. This includes all over-the-counter medicines, herbal remedies, and ointments/creams. The physicians monitor all resident medications and adjust them as needed. If any medications are found in resident rooms they will be destroyed and an investigation conducted as to where they came from. If your loved one expresses a need for additional medication, notify the nurse manager or physician for assistance.